A COMPARISON STUDY OF THE EFFECTIVENESS OF INDIVIDUAL AND GROUP PLAY THERAPY IN TREATING KINDERGARTEN CHILDREN WITH ADJUSTMENT PROBLEMS

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This study was designed to determine the effectiveness of individual child-centered play therapy in the elementary school in: 1) enhancing the self-concept of kindergarten children who are experiencing adjustment difficulties; 2) decreasing the overall behavioral problems of kindergarten children experiencing adjustment difficulties 3) decreasing externalizing behavior problems such as aggression and delinquency of kindergarten children experiencing adjustment difficulties; 4) decreasing the internalizing behavior problems such as withdrawal, somatic complaints, anxiety and depression of kindergarten children experiencing adjustment difficulties; 5) increasing parental perception of change in the problematic behaviors of kindergarten children experiencing adjustment difficulties; and 6) enhancing self-control in kindergarten children experiencing adjustment difficulties. A secondary objective was to compare the participants involved in individual child-centered play therapy with participants in a previous study who were involved in child-centered group play therapy on the above named dimensions.

The experimental group, consisting of 14 kindergarten children experiencing adjustment difficulties, received 10-12, 30-minute individual play therapy sessions in a 12

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CHAPTER 1

INTRODUCTION

Among the approximately 31.5 million children enrolled in elementary schools across the U.S. (U.S. Census Bureau, 1996), several thousand are dealing with such intense issues that they are not able to comply with their teachers' expectations for them. Issues commonly impacting elementary school children include significant learning or behavioral problems, withdrawal, performance anxiety, hyperactivity, high anxiety, underachievement, truancy, high absenteeism, school phobia, impulsiveness, and aggression. Often in the counseling process, it becomes apparent that a child's presenting issue is just a surface problem precipitated or exacerbated by events in the child's life, such as divorce, separation, chronic marital discord, or depression in one or both parents (Aust, 1984).

Educators are interested in finding interventions for children because psychological problems can hinder children's readiness for learning (Pianta, 1997) and lead quickly to educational failings (Cowen, 1973). "It is a well established concept that the emotional life of the child has a central bearing on his readiness and his freedom to learn. Incapacitating fears, anxiety, and hostility serve as a potent block to educational progress" (Seeman, 1954, p. 493). It is estimated that 14%-22% of all children experience developmental, emotional, and behavioral disorders (Mash & Dozois, 1996).

Children entering kindergarten often face special challenges in the form of loss of self-esteem, largely because children at this developmental stage begin comparing

themselves for the first time to classmates in the areas of abilities, behavior, appearance, and other characteristics (Marsh, Barnes, Cairns, & Tidman, 1984; Stipek & MacIver, 1989). Children's perception of themselves academically has been found to be highly predictable of school achievement and children's unwillingness to give up when faced with challenging tasks (Marsh, Smith, & Barnes, 1985). Children who view themselves positively have been found to be consistently more liked by peers (Harter, 1982).

The externalizing behaviors and cognitive functioning problems of children ages three to five years have been found to be sound and stable predictors for continued problems in the first grade (Heller, Baker, Henker, & Hinshaw, 1996). Early intervention to address children's social and emotional difficulties is needed to provide them with optimal opportunity for school success. Recent social changes and conditions place younger children at increased risk for developing disorders and more severe problems at younger ages. Some of these changes and conditions which impact children include increasing occurrence of single parenting, pressures of broken families, financial pressures, adjustment problems within immigrant families, maltreatment, drug and alcohol use in the family, prematurity, and HIV (Mash & Dozois, 1996).

The developmental needs of kindergarten children need to be considered when selecting an appropriate counseling intervention. For a counselor to effectively communicate with a kindergarten-aged child at the child's cognitive and social-emotional level, the use of play materials is essential (Landreth, 1987). Children's most natural medium of expression is play (Axline, 1969; Ginnott, 1961; Landreth, 1991) and children use toys as their words to express emotions (Campbell, 1993; Ginott, 1961; Landreth,

1993). Thus, play is how children express their feelings, explore relationships, and explore self. Piaget (1962) described play as the bridge between the gap of concrete experience and abstract thought. The symbolic function of play allows the child to deal in a sensory-motor way, through concrete objects, with what has been directly or indirectly experienced. Schaefer (1993) reported play has at least 25 therapeutic powers, including releasing of hostility toward parents, alleviating guilt, overcoming resistance, catharsis, mastering of developmental fears, desensitization by repetition, insight, attachment, self-actualization, and ego strength.

Kindergarten teachers often provide children with opportunities to play, but play alone is not enough to address the intense needs of children with adjustment difficulties. Adjustment difficulties for kindergarten children arise for several reasons. Emotional disorders of children may cause adjustment difficulties that make it impossible for the children to experience success in a learning environment. Depression and anxiety may cause internal distraction and prevent children from focusing on learning tasks. An additional cause of adjustment difficulties in kindergarten children may be learning disabilities, as the disabilities reverberate through a child's being (Landreth, Allen, & Jacquot, 1969). Stressors in the home may also create adjustment difficulties, and the accompanying inner turmoil may preoccupy thoughts of children and distract them during classroom instruction (Adelman & Taylor, 1991).

Children with adjustment difficulties need early intervention beyond the play offered in their school setting. Play therapy may be used by school counselors to meet the broad range of developmental needs of children (Landreth, 1987). Play therapy

procedures provide children the opportunity to resolve adjustment difficulties that hinder emotional and social development and assists them in gaining the maximum benefit from learning experiences, thus increasing their academic success (Axline,1969; Campanelle, 1971; Quayle, 1991).

There exists a lack of controlled and comparative experimental evidence to verify the effectiveness of individual play therapy in the school setting with young children. Additional studies are needed in order to evidence the efficacy of play therapy, specifically individual child-centered play therapy, as a viable and even necessary modality for treatment in young children.

Purpose of the Study

The purpose of this study was to determine the effectiveness of individual child-centered play therapy in the elementary school setting in: 1) enhancing the self-concept of kindergarten children who are experiencing adjustment difficulties; 2) decreasing the overall behavioral problems of kindergarten children experiencing adjustment difficulties; 3) decreasing externalizing behavior problems of kindergarten children experiencing adjustment difficulties; 4) decreasing the internalizing behavior problems of kindergarten children experiencing adjustment difficulties; 5) increasing parental perception of change in problematic behaviors of children experiencing adjustment difficulties; and 6) enhancing self-control in kindergarten children experiencing adjustment difficulties. A secondary objective was to compare the participants involved in individual child-centered play therapy with participants in McGuire's (1999) previous study who were involved in child-centered group play therapy.

Review of Related Literature

The following review is a synthesis of historical literature and research related to four major areas: (1) individual play therapy in elementary schools; (2) group play therapy in elementary schools; (3) the effectiveness of play therapy; and (4) comparisons of individual and group play therapy.

Individual Play Therapy in the Schools

As early as 1909, play was used in the therapeutic realm to help children communicate their inner world. Essentially, play therapy began as an extension of psychotherapy (Bishop, 1971). Sigmund Freud had one psychiatric session with a boy referred to as "Little Hans" and then decided to use what the father described about the child's play to assist the father in addressing the child's emotional turmoil (Bishop, 1971; Landreth, 1991). Soon afterward other therapists began using play in therapy with children: Hermine Hug-Hellmuth (1921), Melanie Klein (1919/1955), and Anna Freud (1946/1965). Klein and Freud primarily treated seriously disturbed children in child guidance clinics and considered play therapy as parallel to the process of adult free association. They used the information children provided in play sessions as the basis for interpretation (Bishop).

Before the 1960's, clinicians in private practice had provided services to children in elementary schools, with a focus primarily on treating maladjusted children. In the 1960's play therapy began to be used in elementary schools, a time when mental health professionals struggled with the ineffectiveness of previous interventions implemented with children. Alexander (1964), Landreth (1969), Landreth, Allen, & Jacquot (1972),

Muro (1968), Myrick and Haldin (1971), Nelson (1966), and Waterland (1970), were among the first counselors to write about their successful experiences with play therapy in the schools. Guidance and counseling programs emerged out of this struggle to create effective services for children (Campbell, 1993; Landreth, 1991).

Bishop (1971) suggested play therapy in the schools was better termed "play processes" because it was more than an extension of therapy as it had been known for adults. Myrick (1987) also addressed the issue of what to call play therapy in the schools by making a differentiation between "counseling" and "therapy" based on the setting, severity of problems and the duration of treatment. He proposed counseling took place in the schools, whereas therapy took place in clinical and medical settings and asserted anything in the school setting is still called counseling, even if the counselor is trained as a therapist and implements sophisticated techniques. Myrick cautioned school counselors that the line is blurred, and they should be prepared in advance to refer children to outside agencies when they assess before intervention or discover amidst intervention that the issue to be addressed cannot be dealt with adequately in the time frame they have available.

Landreth (1987) suggested there should not be a question of whether or not an elementary school counselor should use play therapy, but instead a question of how play therapy should be used in the schools. Campbell (1993) asserted play is an important part of a guidance program in any elementary program and should be fused into the program.

One of the first studies of play therapy in the elementary school setting

demonstrated the effectiveness of child-centered play therapy with poorly adjusted slow readers (Bills, 1950). Thirty-two children in a class of third-graders were identified by teachers as having delayed reading development and slow reading speed for their age. Eighteen of the children comprised the treatment group, four dropped out, and the remaining 10 children were used as a comparison group. During the treatment phase of the experiment, the children were seen in six individual play sessions and three group play therapy sessions. The children demonstrated significant increases in their reading ability when compared to the control group. Bills proposed play therapy was effective with these children because it impacted both their inconsistent attitude toward reading and their view of themselves as poor readers.

Alexander (1964) implemented weekly child-centered play therapy sessions in an elementary school setting with a child who displayed extreme anxiety and detached responses. This child's teacher described the child as sometimes desperately clinging to her, having a far away look in his eyes, not responding when spoken to, and responding in irrelevant or unrelated sentences. Through play therapy, the child began to slowly express his fears and gradually changed his attitude toward his father.

Azar (1979) investigated the effectiveness of concurrent play therapy and reading enrichment sessions with children who had been identified as having poor self-concepts and low reading achievement. The concurrent weekly intervention was implemented for three months, and the results of the study indicated it significantly increased self-concept and reading achievement. Crow (1990) implemented ten 30-minute, school-based child centered play therapy sessions with first grade students who were low achievers in

reading, had low self-esteem, and were repeating first grade. The 12 students showed significantly increased self-concepts when compared to a matched control group.

Quayle (1991) demonstrated the effectiveness of play therapy with children exhibiting adjustment problems. Fifty-four children aged 5 to 9 years who were experiencing school adjustment problems, such as acting out, moodiness, or learning difficulties, were divided into a treatment group that received twenty 30-minute play therapy sessions, a comparison group that received twenty 30-minute individual tutoring sessions, and a control group that received no intervention. After play therapy, the children in the treatment group demonstrated the most positive growth when compared to the comparison and control groups in the areas of improvement of learning skills, assertive social skills, task orientation, peer social skills, interactive participation, and self-confidence. Results of other research studies have demonstrated play therapy to be an effective intervention for learning readiness with socially immature kindergarten children (Pelham, 1972) and children with learning difficulties (Siegl, 1970).

Baggerly (1999) utilized Landreth's (1991) 10-week filial therapy model to train fifth grade students to conduct special play sessions with at-risk kindergarten children. The results of her study suggested the application of this model of filial therapy to train fifth grade students was effective in decreasing somatic complaints as measured by the Child Behavior Checklist Teacher Report Form. Positive trends were also noted in increased children's self-concept as measured by the Joseph Pre-school and Primary Self Concept Screening Instrument, decreased total behavior problems and externalizing behavior problems as measured by both the Child Behavior Checklist Teacher and Parent

Report Forms, decreased delinquent behavior problems as measured by the Child Behavior Checklist Teacher and Parent Report Forms, and decreased parenting stress related to the overall child domain and the demandingness scale of the Parenting Stress Index.

Group Play Therapy in the Schools

Another form of intervention in elementary schools implemented by school counselors has been group play therapy. In the early 1970s, there was a trend toward considering the use of group play therapy in school guidance and counseling programs as the most effective and efficient intervention (Dinkmeyer & Caldwell, 1970; Dinkmeyer & Muro, 1971; Howard & Zimpfer, 1972; Myrick & Haldin,1971; Ohlson 1970). Some of the reasons group therapy was considered advantageous over individual therapy included: Children are able to learn vicariously from each other and from the interaction in their relationships. Children are already involved in group style learning in the classrooms and on the playground. Seeing children in groups would be a more efficient way to see many children (Dinkmeyer & Caldwell, 1970; Dinkmeyer & Muro, 1971).

Gaulden (1975) investigated the effectiveness of developmental play group counseling with elementary school children and found it was significantly beneficial to children exhibiting behavioral problems in the classroom. Forty-eight children were identified by their Title I teachers as being one or more standard deviation(s) above the mean on the "classroom disturbance factor" of the Devereux Elementary School Behavior Classroom Rating Scale (DESBCRS). Twelve children in the four schools were randomly assigned in groups of four to a treatment group that received developmental

play group counseling, a treatment group that received play group counseling, and a control group. Both treatment groups received bi-weekly 45- minute sessions for a total of 7 weeks. The results indicated the children in the play group counseling made significant positive change of one or more standard deviation(s) on the DESBCRS compared to the control group and maintained this level of improvement eight weeks after the study.

Gould (1980) studied the effectiveness of group play therapy with children with low self-image. Eighty-four elementary school children were randomly assigned to either a treatment group utilizing nondirective group therapy as an intervention, a placebo group which participated in group discussions, or a control group with no intervention. The results of the study showed children who participated in group play therapy had the strongest positive change when compared to the other groups.

Documenting the Effectiveness of Play Therapy

There have been several studies that examine the effectiveness of play therapy in treating or reducing the impact of multiple issues children bring to play therapy. These studies identify changes in the children's behavior before and after therapy. Specifically, these studies support the effectiveness of individual play therapy in helping children deal with abuse, neglect, aggression, acting out, attachment difficulties, autism, chronic illness, deafness, physical challenges, dissociation, schizophrenia, emotional disturbance, enuresis, encopresis, fear, anxiety, grief, mental challenge, reading difficulties, selective mutism, self-concept, self-esteem, social adjustment, speech difficulties, traumatization, and withdrawal.

Abuse and neglect. Burch (1980) found a 13-year-old boy′s puppet play in play therapy sessions helped the child gain insight into his past and faith in his future. Before play therapy, the child exhibited a very high level of anxiety, considered himself as "bad ," and experienced social and academic problems. His behaviors in play therapy sessions reflected his concern with issues about his ethnicity, abuse, neglect, and abandonment. Birch reported that through play, the child replayed and effectively dealt with the trauma of his abandonment from his biological mother and the abandonment and abuse from his adoptive family.

Friedman (1983) described the effectiveness of play therapy with a severely neglected child after he had been hospitalized and placed with a foster family. The child had been hospitalized in a comatose state due to his complete deprivation of all liquids by his mother during a heat wave. She had attempted to “cure” him from enuresis. Before play therapy, the child did not speak and did not play, behaving almost mechanically with little display of affect. He also lacked initiative and an ability to experience pleasure, and did not enjoy participating in many activities. After just 4 months of weekly play therapy sessions, he was able to ask for a toy or food. And after 7 months, he became animated, spontaneous, and emotionally expressive in his play. He was able to express symbolically in his play the strong negative emotions he felt toward his mother. According to Friedman, the child used play to express himself in a healing manner, which helped him become assertive, even toward authority figures outside of play therapy sessions.

Klem (1992) reported on a 6-year-old boy who was able to disclose physical and

sexual abuse during play therapy. Upon referral for play therapy, the child was developmentally delayed, disruptive, destructive and preoccupied with death. He had begun exposing himself and trying to sexually touch other boys at school. When he experienced safety in the playroom and the availability of concrete play with the dollhouse, he acted out the abuse he was experiencing at home. His play enabled him to develop a sense of control so he could obtain a place of safety for himself.

A 6-year-old child in a case study by West (1983) had been severely neglected and emotionally abused, and was manipulative, attention-seeking, control-seeking, and achieving poorly in school. The child had lived in a home with four siblings until her prostitute mother had killed a man, and the child had helped clean up the blood. The child then moved in with a neighbor until her father was hospitalized after she found him attempting suicide. She began child-centered play therapy 3 months after she was placed in foster care and continued for 15 months. According to West, the child used the freedom she experienced in play therapy to self-direct getting her own needs met. She "regressed" in her behaviors in the play room and then used play therapy to emotionally "mature" at her own pace.

Aggression and acting out. Several studies have found play therapy helps children to become self-motivated to decrease their own aggressive acting-out behaviors. Levy (1939a) used play therapy with a 2-year-old girl displaying severe temper tantrums that often lasted two hours in duration. The child also exhibited a negative and sulky attitude and lacked emotional connection with her parents and 4-year-old brother. Levy

worked with this child for 10 sessions during which he used general release play therapy, believing the child's behavior was the result of excessive demands placed on her for potty training too early for her developmental age. Levy's objective was the child would release her anxieties through the use of therapeutic self-regression and that the child would then be free to express herself through the various play materials once she released her constricting emotions. After her third session, the child began to display affection to her family, expressed less of a negative attitude, was more compliant with parental requests, and played freely with other children. During the fourth through tenth sessions, the child symbolically played out her issues with potty training, while simultaneously dealing with her conflicting emotions about this issue at home.

Ude-Pestel (1977) worked with a severely acting-out child, a 6-year-old girl whose behaviors included temper tantrums, screaming, beating her head against the floor, running around the house naked, pulling out her hair, and being aggressive toward her younger brother. This was a child who had already begun to express her emotional pain by acting out and also in expressive art through approximately 1,500 pictures and paintings prior to coming for play therapy. These pictures were primarily of ghosts, skulls, and monsters that over the course of therapy were replaced by pictures of friends, animals, and ice-skating. Ude-Pestel felt psychoanalytic play therapy helped the girl in expressing herself, stopping the problematic behaviors and healing on her own terms.

Par (1990) used play therapy to help a 4-year-old boy who came from a home life that did not encourage the expression of his emotions. The boy's mother was very strict with some compulisve tendencies and his father was often unavailable to the entire

family. Both parents had unrealistically high expectations for the child, the oldest of four, to control his own behavior. He struggled with aggressive tendencies, phobias about the dark and animals, noncompliance with authority figures, poor peer relations, and poor dietary habits. Play therapy helped him to face his issues of anger, fear, and control, and helped him to express his emotions in more acceptable ways.

Allan and Brown (1993) documented the effectiveness of Jungian play therapy with an 8-year-old boy who had disruptive and aggressive behaviors in the classroom and on the playground. The boy was struggling with the separation of his parents just before he started the school year. He was seen at school in play therapy sessions daily for one week and then once a week, for a total of 15 sessions. One year later, he was described as exhibiting improved coping skills and positive behaviors both at school and home.

Attachment difficulties. Colbert (1971) reported a case study of a 9-year-old girl who had experienced continual rejection from her parents who showed favoritism toward her three younger siblings. By age 4 years, she had been placed in foster care because of her extreme acting out, and by age 6 years, her behaviors led to her hospitalization. These extreme behaviors included: impulsiveness, aggressive fighting, destructiveness, cruelty and sexual misconduct with animals, defiance, stealing, lying, and fire starting. Through 7 months of child-centered play therapy, the girl was able to express her feelings of rejection and anger openly, deal with them, and then find ways to control or abandon the emotions. She learned from being in a therapeutic relationship that anger was an acceptable emotion, that having a relationship with another person was safe, that she was accepted despite her behavior, and that someone could recognize and understand her pain.

Milston (1989) used play therapy for 2 ½ years to treat an emotionally disturbed child who was experiencing attachment difficulties with his adoptive mother. The boy was the biological child of a teen-aged mother who had been repeatedly hospitalized for depression. By the time the child was 2 years old, he was adopted after being in and out of numerous foster homes due to the neglect and possible physical abuse he had experienced while with his biological mother. Before therapy, the child was overly aggressive, actively stealing, and lying with no signs of remorse or any other emotion. The child's initial behavior in the playroom was unimaginative, helpless, aggressive and rude. After 2 years of structured, behaviorally based play therapy, the child showed some remorse for his inappropriate behavior, began to show affection, began to take pleasure in daily living, and was more willing to accept responsibility for his actions. Crucial to the attachment process and future healing, the child formed an emotional bond with his adoptive mother due to her inclusion in some of the later sessions.

Emotional disturbance. Perry (1988) worked for 3 ½ years with a 9-year-old emotionally disturbed boy. The child had a minor case of microcephaly which was considered a precipitating factor in his emotional difficulties, especially in the trichotillomania. The child's mother depicted his behavior as impulsive, aggressive, and destructive. He also had spoken and written language disabilities, temper tantrums, enuresis, poor attention span, difficulty socializing, poor self-esteem, and was stealing, lying, and pulling out his hair. He had been on Benadryl, Ritalin, Cylert, Melaril, Dilantin, and megavitamins prior to play therapy, none of which had a great deal of success in treating his symptoms. The play therapist intervened with the "ecological

systems" approach, which incorporated weekly child-centered sessions as well as weekly family therapy sessions. During play therapy, the child's difficulties decreased, he developed a relationship with the therapist, and his relationships at home began to stabilize as he worked out his issues in play. As he learned to express his emotions in the playroom both verbally and nonverbally, his acting out behaviors at home diminished.

Fear and anxiety. Levy (1939a) worked in brief play therapy with a 2-year-old boy who had experienced two traumatic incidents in which another child hit and scratched him. After the second incident, the child acted withdrawn, anxious, and fearful and began to stammer. The stammering was considered directly related to the anxiety the child experienced from the two attacks. Levy used play therapy to provide the child an atmosphere of safety so the child could reenact the attacks until his emotions about the experience were released through his aggressive play. After just three sessions, the mother reported the stammering and fear were no longer displayed by the child. At both 1 and 2 year follow-ups, the stammering had not reoccurred.

Conn (1941) utilized play therapy with a 9-year-old girl who was afraid of being kidnaped, afraid of the dark, afraid of being in a dark room alone, afraid of strangers, cried easily, and experienced reading problems. In her first session, the girl verbalized that she really was not afraid a kidnapper would take her younger sister. In the second session, she verbalized she hated her sister because she felt her sister received all her dad's love and she wanted a kidnapper to take her sister away. In the third session, she expressed she had thought about the kidnappers and the dark so long that she had made herself scared. She could now go into dark rooms, turn on lights and go to bed without

crying or needing her father to stay with her, and could interact with strangers more easily. She continued working on these issues for nine sessions and then began playing with children her own age instead of dominating younger ones. Her reading improved in school also.

Machler (1965) used brief play therapy to assist a 10-year-old girl in dealing with her school phobia. Before play therapy, the child had been only able to endure school one day a week and described seeing "little brown men" during periods of extreme fear. The play therapist added Pinocchio puppets to the room because in the original story, a young boy has difficulty with school and eventually his life changes for the better despite his troubles and irresponsible behavior. The therapist allowed the child to decide if and when she played with the puppets. She chose to add them to her play themes in the third session. She acted out Pinocchio missing school even though Jimminy Cricket warned him about trouble because of his choice. She chose the Pinocchio puppet again in her fourth session where she played exclusively with him while she had the therapist play the other characters. During that session, she had Pinocchio admit he liked school and wanted to learn, but he had his reasons for not wanting to go to school. After five play therapy sessions, the child displayed excitement about learning in school and told her therapist the little brown men had not been real and that she wanted the therapist to tell her parents the men would not return. She seemed pleased about the changes in her perspective.

Barlow, Landreth, and Strother (1985) reported on child-centered play therapy with a 4-year-old girl who exhibited extreme behavior problems, including temper

tantrums, thumb-sucking, and pulling out all her hair and eating it. The child began experiencing fear of separation from her mother after the birth of a new sibling, and the mother was so overprotective of the new baby she did not have time for the older child. In addition, the mother had been hospitalized often with an illness, and both the mother and grandmother were overcontrolling of the girl's behavior by placing limits on nearly everything she did. The child responded with rebellion. She was treated once a week with eight total child-centered play therapy sessions. By the fifth session, her hair had already begun to grow back and she had begun to resolve her inner conflict. In the seventh session, the child's head was covered with short hair, and she verbalized an awareness of her habit. According to Barlow, Landreth, and Strother, the child learned to express her thoughts and feelings, explore relationships, organize her experiences, and experiment in order to resolve her inner conflicts in the safety of the play therapy experience.

Grief. Carter's (1987) case study of a 10-year-old boy who witnessed his father's murder demonstrates how a child's coping skills can improve with play therapy intervention. After witnessing his father's murder, he was aggressive, often hitting peers and teachers, destroying property, and using profanity. He refused to talk about his father or the murder, and his academic progress was blocked to the point that he was placed in a class for emotionally disturbed children. Nondirective play therapy sessions provided him with a safe place to express and accept his experiences of grief and anger. After eight sessions, his teacher reported his academic performance and his social skills were improving, he was expressing anger in an appropriate way, and he appeared to have joy in

his life again. Eventually, the child was mainstreamed back into a regular classroom with fewer acting-out behaviors, where he displayed confidence and talked about himself as being successful in his future.

LeVieux (1994) reported on play therapy with a 5-year-old girl who was described as defiant, uncooperative, moody, irritable, depressed, and impatient with her younger siblings following the death of her father. The girl was referred for treatment 6 months after her father's death, but only because of her mother's concern about the child's crying and fear reaction to her preschool teacher's pregnancy. Following her seventh play therapy session, her mother reported she could talk about the death of her father. LeVieux reported the child made progress in integrating the death of her father and processing her grief and anger issues.

Selective mutism. Axline (1971) used nondirective play therapy with a 5-year-old electively mute boy. The boy's mother reported he had suddenly stopped talking and walking at age 3, essentially regressing to an infantile state after the mother had been hospitalized for emergency surgery. The child had then been diagnosed by a physician as "feebleminded" as by not speaking, he had earned a score of 68 on an IQ test. The boy was currently not speaking to anyone at the school, although 6 months earlier he had been verbal and interactive. He would not listen to stories the teacher read, he would crawl along the wall in the classroom, and he would roll up into a ball and hide his face whenever others would approach him. In his third play therapy session, the boy began making a few comments to the therapist, in the fourth he talked with the therapist, and by the fifth session he was demonstrating increasingly appropriate behavior at school.

Eventually, the child was seen in group play therapy to help increase his social skills. One year after termination, the mother reported that the child had been retested and earned an IQ score in the average range and he was doing well in school and in social situations.

Barlow, Strother, & Landreth (1986) found a combination of child-centered individual play therapy, child-centered sibling group therapy, and parent consultation to be effective in helping a five-year-old girl find the freedom to talk. The authors reported the child found in play therapy a place of safety and trust, where she could be completely comfortable and not experience any pressure to talk. After 9 months of play therapy, she had increased her verbal communication skills and social skills to the point that she was moved from a special education class into a mainstream classroom.

Speech difficulties. Jackson (1950) utilized play therapy with a 3 ½ -year-old boy who had such severe speech regression that it was difficult to determine if the child heard or understood a word spoken to him. The child was fully functioning until his first sibling was born when he was 20 months old. Between the birth of this sibling and the birth of the next one 14 months later, the child had also experienced being hit by his maternal aunt as a form of discipline and was hospitalized for circumcision, after which he screamed nightly for long periods. The boy also exhibited regression, aggression toward younger children, enuresis, and encopresis. He had been uncommunicative during psychological testing and earned a score in the mentally retarded range on his IQ test. It was at this point his mother referred him for treatment to obtain a second opinion. After 64 weekly play therapy sessions over an 18-month period, the boy's behavioral

problems at home stopped and he began participating in conversations. He continued to experience difficulty in language, such as telescoping sentences and cutting out prepositions and conjunctions. But at age 7, he earned a score of 149 on an IQ test, with a mental age of 10 years, 8 months.

Dupont, Landsman, and Valentine (1953) described a case study of an 8-year-old boy who exhibited emotionally induced speech delay and aggression. The boy had suffered from maternal deprivation, neglect, and multiple rejections. His father had been sent to prison when he was 3-years-old, and the boy and his older brother had been placed in foster care after his mother became unable to care for all her children. The child was to be moved to a permanent foster care placement after a year of temporary placement, but the new foster mother could not accept his speech delay. Before play therapy, his speech was assessed to be at the level of a 3-year-old, garbled and unintelligible. After 1 year of individual play therapy, his speech was almost completely intelligible and he initiated speech freely and frequently.

Traumatization. Maclean (1977) described the effectiveness of psychoanalytic play therapy in helping a 3-year-old boy cope with the traumatic shock he experienced after he and his father were attacked by a tiger. After the attack, the child had been suffering from nightmares, extreme anxiety, reluctance to separate from his mother, and excessive worry about his parents' whereabouts. The child received weekly individual play therapy for 8 months. He spent large amounts of time in the initial sessions reenacting the trauma. He would often play the role of the tiger in attacking the therapist and ask to cut the sessions short for fear of retaliation. He also dealt with anger toward

his father for allowing the attack to occur. His symptoms decreased during treatment and at termination, they had disappeared.

van Zyl (1977) found play therapy to be effective with a 2-year-old boy who had experienced the trauma of inadvertently being left at school by his mother in an empty classroom after his class had already left on a field trip. After this event, the boy experienced fear of going to school and developed enuresis. His parents also had concerns about his hyperactivity, fearfulness, and complaints of loneliness they thought were associated with death. The boy had 20 sessions of individual play therapy once a week and was able to gain a sense of power and control in the playroom by reenacting the trauma symbolically as a way of distancing himself from it. The child's parents terminated the sessions when the child's enuresis had improved, his hyperactivity had decreased, and he could accept being left alone again.

Allan and Berry (1987) reported on play therapy with a second grade boy who was dealing with unresolved issues about moving in with a father he did not know and a new stepmother and her two daughters. Prior to entering play therapy, the child had been living in his father's home for 2 years, and he had been exhibiting aggression, impulsive behaviors, and poor social skills in his classroom and on the playground. The boy used the sand play to express his unresolved trauma in a way he could control. After 10 sessions of play therapy, his teachers reported a decrease in his problematic behaviors as well positive as changes in his life with the additions of art and soccer as outlets for emotional and physical energy.

Gil (1991) treated a 7-year-old girl who had experienced the physical trauma of an

appendicitis and then the disappearance of her parents for four days following her surgery. Nine months of nondirective play therapy were implemented, with toy hospital equipment being added to the playroom after the child made reference to her surgery. The girl had been in foster care for 18 months prior to her surgery while her parents completed drug rehabilitation treatment. She then became a ward of the state when her parents were unable to be found during her surgery. She had experienced neglect, malnourishment, minor infections, impetigo, and a visual problem while living with her parents. She had been reunited with her parents before play therapy began, but was having difficulty adjusting to being with her parents again and with missing her foster family with whom she had formed a strong positive attachment. Through nondirective play therapy, with occasional directiveness by the play therapist in talking with the child about life with her parents and her surgery, the child was able to work through her emotional issues. According to Gil, the child's need to take care of her parents had been interfering with her dealing with her own issues of fear regarding her hospitalization, loss of her foster family, and resentment and anger at her parents' abandoning her.

Kot (1995) used a pre-post-test control group design to assess the effectiveness of intensive child-centered play therapy with children who witnessed domestic violence. An experimental group and a control group were formed from the 22 children, aged 3-10 years, from three shelters. Both groups continued receiving shelter services consisting of three educational/recreational groups per week, but the treatment group also received twelve 45-minute individual, child-centered play therapy sessions within a 2-week period. The treatment group showed significant improvement in self-concept and in the play

behaviors of physical proximity and play themes, as well as significant reduction in their externalizing behavior problems and their total behavior problems.

Withdrawal. White (1957) worked with a 5-year-old girl who had been hospitalized after she stopped eating following her father's death. The child had experienced an inappropriate amount of attention and "spoiling" from her father, seemingly because he wanted to bond strongly with her after missing out on much of an older daughter's childhood while he was at war. The child had been held and fed by her father at mealtimes. She allowed only him to read her to sleep and always slept with one of his shirt collars at night. After he died, she refused to eat, believing if she grew her father would not recognize her. During her hospitalization, she was seen in play therapy 1 hour a day for one week. After her first session in which she and the therapist nurtured dolls, she began to eat miniature cookies and milk, but still refused to eat solid food. As an outpatient, she was seen daily in play therapy for another week. During this second week, the mother began to receive reports the child was eating at neighbors' houses and she began to sit down and eat at home too. After 6 months, she was interested again in food and her eating stopped being an issue of concern in therapy. At the 3-year follow-up, she reportedly was continuing to eat normally and she also had stopped experiencing nocturnal enuresis.

Studies Comparing Individual and Group Play Therapy

Pelham (1972) utilized group and individual play therapy with kindergarten children identified by their teachers as socially immature. Nine teachers referred 52 children, and 18 of these children were randomly selected to be in the control group. Of

the remaining 34 children who were randomly selected to be in the experimental group, only 17 parents gave consent for their children to be in the experiment. Nine of these 17 children were assigned to participate in group play therapy in groups of three, while eight were assigned to individual play therapy. Both experimental groups received six to eight 45-minute play therapy sessions. Pelham reported both groups made positive gains when compared to the control group, but there was no significant difference in the increase of social maturity between the groups that received individual or group play therapy. The results of this study found both groups made positive gains when compared to the control group, but there was no significant difference in the increase of social maturity between the groups that received individual or group play therapy. Both groups' measured self-concepts increased. Both groups also received more positive reports from the teachers on their classroom behaviors after play therapy.

Perez (1987) compared individual and group play therapy with a control group in order to determine the most effective form of treatment for sexually abused children. The treatment group consisted of 45 children between the ages of 4 and 9 years. Perez reported play therapy experiences gave these children a setting in which to reorganize their traumatic experiences, gain self-control over the events, and increase their positive self-concept and ability to experience self-mastery. Although there was no significant difference between individual and group play therapy, Perez identified advantages of group play therapy in helping children validate their experiences by talking with other children, reducing their sense of isolation, and experiencing relationships where abuse did

not occur.

Tyndall-Lind (1999) compared the effectiveness of sibling group play therapy and individual play therapy for child witnesses of domestic abuse. The results of her study suggested sibling group therapy was effective in increasing the children's self-concept and decreasing behavioral problems as compared to a control group. Sibling group play therapy was found to be more effective than individual play therapy with this population in reducing somatic complaints, aggression, and withdrawal.

Summary

Both group and individual play therapy are effective interventions to assist children in dealing with a variety of issues in their lives. Providing play therapy in the elementary school where a child attends can be particularly helpful for children with adjustment problems, in that these problems often originate in the school and other problems can be exacerbated by the school experience (Schiffer, 1969). Schools are becoming more and more populated, increasing school counselors' case loads. It would be helpful for counselors to have knowledge about whether one modality is more effective than the other as their resources are limited.

CHAPTER II

METHODS AND PROCEDURES

The purpose of this study was to compare individual child-centered play therapy and child-centered group play therapy in an elementary school setting by examining their effectiveness in: 1) enhancing the self-concept of kindergarten children who are experiencing adjustment difficulties; 2) decreasing the overall behavioral problems of kindergarten children experiencing adjustment difficulties; 3) decreasing externalizing behavior problems of kindergarten children experiencing adjustment difficulties; 4) decreasing the internalizing behavior problems of kindergarten children experiencing adjustment difficulties; 5) reducing problematic behaviors of kindergarten children experiencing adjustment difficulties; and 6) enhancing self-control in kindergarten children experiencing adjustment difficulties. This chapter provides a definition of terms, hypotheses, instrumentation, selection of participants, collection of data, procedures, and statistical analysis.

Definition of Terms

Adjustment difficulties are defined as problems that interfere with a child's adjustment to school, classroom experiences, and learning opportunities. Examples of adjustment problems include depression, anxiety, withdrawal, inattentiveness, impulsivity, phobias, excessive shyness, and grief reactions to life changes such as a recent move, death of a family member, or parental divorce.

Child-centered play therapy procedures and skills are therapeutic strategies of tracking behavior, reflecting content and feelings, building self-esteem, facilitating decision making, and setting therapeutic limits. These strategies are implemented by trained facilitators who build therapeutic relationship by demonstrating warmth, empathy, and genuineness through tone of voice, posture, and active listening. Selected therapeutic toys are provided as a means for children to express their thoughts, desires, perceptions, and feelings (Baggerly, 1999).

Externalizing behavior problems are behaviors that are outward manifestations of inner conflict. These behaviors can include: aggression, hyperactivity, and conduct problems. For the purposes of this study, externalizing behavior problems was operationally defined as the score on the Externalizing Behavior subscale on the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Group play therapy was defined as a system of relationships between two or more children, a trained play therapist implementing play therapy procedures and skills, and selected play materials to help children more fully express and explore their experiences, thoughts, feelings, and behaviors, and to enhance their interpersonal and social skills--through play (Landreth, 1991; Slavson & Schiffer, 1975). For the purposes of this study, all play therapists implemented child-centered procedures and skills.

Individual play therapy was defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully

express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p.14). For the purposes of this study, all play therapists implemented child-centered procedures and skills.

Internalizing behavior problems are a cluster of behavioral characteristics which are symptomatic of an attempt to cope with internal difficulties. Most often emotions are prevented from being expressed and they are instead directed internally. Behavioral characteristics include withdrawal, anxiety, depression and suicidal ideation. For the purposes of this study, internalizing behavior problems was operationally defined as the score on the Internalizing Behaviors subscale the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Self-Control is the ability of a child to delay and/or decrease impulsive behaviors. For the purposes of this study, self-control was operationally defined as the score on the Self-Control Rating Scale (Kendall & Wilcox, 1979).

Self Concept refers to the underlying attitude and or internal measure that a child holds about his or her self worth. The child forms a sense of self based on outside experiences and inside perceptions. For the purposes of this study, self-concept was operationally defined as the score on the Joseph Pre-school and Primary Self Concept Screening Test (Joseph, 1979).

Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

1) Children in the individual play therapy treatment group will attain a significantly higher mean total score on the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS) post-test than will the children in the control group.

2) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the parent form of the Self-Control Rating Scale (SCRS) post-test than will children in the control group.

3) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than will children in the control group.

4) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Child Behavior Checklist-Parent Form (CBCL-Parent Report) post-test than will the children in the control group.

4a) Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Externalizing Behavior Problems Subscale" on the CBCL-Parent Report post-test than will the children in the control group.

4b) Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report post-test than will the children in the control group.

5) Children in the individual play therapy treatment group will attain a significantly lower mean total scale sum score on the Early Childhood Behavior Scale (ECBS)

teacher post-test than for children in the control group.

6) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Self-Control Rating Scale (SCRS) teacher post-test than will the children in the control group.

7) Children in the individual play therapy treatment group will attain a significantly higher mean total score on the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS) post-test than will the children in the group play therapy comparison group.

8) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Self-Control Rating Scale (SCRS) post-test than will children in the group play therapy comparison group.

9) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than will the children in the group play therapy comparison group.

10) Children in the individual play therapy treatment group will attain a significantly lower total CBCL-Parent Report mean post-test score than will the children in the group play therapy comparison group.

10a) Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Externalizing Behaviors Problems Subscale" on the CBCL-Parent Report post-test than will the children in the group play therapy

comparison group.

10b) Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report post-test than will the children in the group play therapy comparison group.

11) Children in the individual play therapy treatment group will attain a significantly lower mean total scale sum score on the Early Childhood Behavior Scale (ECBS) teacher post-test than children in the comparison group.

12) Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Self-Control Rating Scale (SCRS) teacher post-test than will the children in the group play therapy comparison group.

Limitations

This study has the following limitations:

1. Subject selection was limited to volunteers from two elementary schools in the Denton, Texas, area, and this produced small sample size in the experimental, comparison and control groups, which were not racially balanced samples.
2. This study relied on volunteer sampling. Due to the nature of the population and the purpose of this study, random selection was not possible.
3. Participants in the individual child-centered play therapy treatment group were

seen in the Fall semester, and children selected for the group play therapy comparison group were seen in the Spring Semester. Some variance may be present due to the differences in the time of the year children were seen.

4. Parents and teachers who will be completing the CBCL, the ECBS, the the FPC, and the SCRS will be aware their children will be receiving therapy. This knowledge may bias the parents' ratings.
5. Parents and teachers rated the children's behaviors during the first month of school. This may have biased parents' and teachers' perception that the identified children would have continued problematic behaviors.

Instrumentation

Joseph Pre-school and Primary Self-Screening Test

The Joseph Pre-school and Primary Self-Concept Screening Test (JSCS) was originally designed by Joseph (1979) to measure the self-concept of preschool children and was later adapted for upper grade levels. Testing procedures involve children's identification of pictures which they view to be most similar to themselves. By using pictures accompanied by descriptions of activities and the feelings surrounding those activities, the test administrator rates the child's self-esteem on a global index of 0 to 30.

The JSCS can be used with children ranging in age from 3 years, 6 months, to 9 years, 11 months. This testing protocol does not require reading ability nor does it require a high level of administrator training. The 30-item test is a desirable quality for this test due to the short attention span of young children (Joseph, 1979).

A test-retest sample established a reliability coefficient of .87. The Kuder-Richardson (20) formula established the internal consistency reliability to be between .59 to .81 with a median correlation coefficient of .73. All test items have been shown to significantly contribute to the overall test score performance. Construct validity was addressed by correlating the global self-concept score with teacher ratings from the Self-Concept Judgement Scale. The correlation coefficient was .051 which was significant at the .01 level of confidence (Joseph, 1979).

Self-Control Rating Scale

Parents and teachers were asked to complete the Self-Control Rating Scale (SCRS)) (Kendall & Wilcox, 1979), to determine the degree of self-control school-aged children exhibit in their observable behaviors. Test-retest reliability was established with a correlation of .84 and with an internal consistency alpha of .98. Construct validity was determined as very good, with significant correlations or predicted lack of correlations with the Peabody Vocabulary Test, Porteus Maze, Matching Familiar Figures, and observer ratings.

Filial Problem Checklist

The 108-item Filial Problem Checklist (FPC)) was developed by Horner in 1974 and is completed by parents to measure problematic child behaviors (Bratton, 1994). The FPC self-report instrument offers 108 potentially problematic situations related to parenting. Parents consider descriptions of situations and mark any they consider a problem for their child with a 1, 2, or 3. A 1 indicates a situation is true for the child, but

not considered a problem. A 2 indicates a situation is considered a moderate problem for a child, and a 3 indicates the situation is a severe problem for the child. Normative statistics concerning validity or reliability are not available on this instrument. The FPC was used as a means to measure parents' perception of change in the children's behaviors.

Child Behavior Checklist

The Child Behavior Checklist (CBCL) (Parent Report form) is a well-established and recognized instrument for the identification of behavior and emotional difficulties in children 4 to 18 years. This checklist was designed to record in a standardized format behavioral symptoms of children which parents or guardians perceive as competencies or limitations. The 113 items, written at a fifth grade reading level, can be completed in approximately 20 minutes. Behavioral symptoms are rated from 0 to 2: with 0- indicating the behavior is not true for this child, 1 indicating the behavior is somewhat or sometimes true for the child, or 2 indicating the behavior is often seen in this child (Achenbach & Edelbrock, 1991).

The CBCL was originally developed by Achenbach and Edelbrock (1986), however, for the purposes of this study, the 1991 revised profile was utilized. The 113 items have been factor analyzed into the following nine subscales (Achenbach, 1991): Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behaviors, Aggressive Behaviors, and Sex Problems. A second-order factor analysis of the Behavior Problem Scale yielded two

primary factors termed Internalizing and Externalizing. Additionally, a total Behavior Problem Scale may be computed and scores for each subscale and factor can be computed to determine T-scores and percentiles. This study primarily focused on the

total Behavior Problem Scale, Internalizing and Externalizing Domains of the behavior scales.

Internal consistency of the CBCL was built in, as the syndrome scales were derived from principle components of the correlation among items. Internal consistency was demonstrated by Cronbach's alpha, which represents the mean of the correlations between all possible sets of half of the items comprising a scale. For girls between the ages of 4 and 11 years, Cronbach's alpha is .90 for Internalizing behavior problems and .93 for Externalizing behavior problems. For boys between the ages of 4 and 11 years, Cronbach's alpha is .89 for Internalizing behavior problems and .93 for Externalizing behavior problems (Achenbach & Edelbrock, 1991).

Inter-interviewer reliability of item scores was established at .959. Intraclass correlations from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores obtained for each other item (Achenbach & Edelbrock, 1991).

Test-retest reliability was established at .89 for Internalizing behavior problems and .93 for Externalizing behavior problems. Scaled scores were evaluated after 2 years to establish long-term stability, which was calculated as being .70 for Internalizing behaviors and .93 for Externalizing behaviors. Children who were receiving mental

health services obtained long-term stability coefficients that were generally lower, with

significant decreases in problem scores, demonstrating this scale is sensitive to the effects of other interventions with children (Achenbach & Edelbrock, 1991).

Content validity of the CBCL is also well established. All 113 items were significantly associated with clinical status at the .01 level of significance. Criterion related validity was supported by the ability to effectively recriminate between referred and non-referred children (Achenbach & Edelbrock, 1991).

Early Childhood Behavior Scale (ECBS)

McCarney (1997) developed the Early Childhood Behavior Scale (ECBS) to document early childhood behaviors which likely identify emotionally disturbed and behaviorally disordered students. Teachers rate students between the ages of two to six years, and the scores are organized into three subscales: Academic, Social Relationships, and Personal Adjustment.

Test-retest reliability was established at a .88 level for the Academic subscale, .81 for the Social Relationships subscale, .91 for the Personal Adjustment Subscale, and .86 for the total score. Inter-rater reliability was established at the .01 level for all ages, with correlation coefficients ranging from .81 to .88, with an average of .85. The Kuder-Richardson 20 formula was used to establish internal consistency. Each of the subscales' reliabilities were .90 or above. Criterion-related validity was determined with coefficients exceeding the .001 level with subscales on the previously described Child Behavior Checklist (McCarney, 1997).

Selection of Participants

Three groups were used in this study: the control, comparison, and treatment groups. Data for the group play therapy comparison group came from McGuire's (1999) study with children who attended kindergarten at one of two identified schools in Denton, Texas, between January, 1999, and May, 1999. These participants were identified as the comparison group for the purposes of this study. Participants who received individual play therapy entered kindergarten in August, 1999, and were identified as the experimental group for the purposes of this study. The control group came from the same population and time period as the treatment group and received no treatment for the time period measured.

Of the two elementary schools, the first school was chosen to participate in this study as an extension to the McGuire (1999) group play therapy study. The second school was chosen because of its close demographic match to the original school. Eleven kindergarten teachers and two school counselors from the identified schools were asked to refer kindergarten children who were having adjustment difficulties in school (see Appendix A). Teachers were told the categories of adjustment difficulties included, but were not limited to, children who were exhibiting shy, withdrawn, anxious, depressed, or inattentive behaviors or who were experiencing life changes such as divorce, moving, or a new sibling. Teachers then ranked the identified children in order of severity, giving priority to the children with the greatest levels of adjustment difficulty.

The teachers requested a general letter be sent to all parents of kindergarten children, informing them of the project (see Appendix B). The intent was to provide

teachers with a reason for getting the identified children involved without promoting fear or guilt in parents that something might be wrong with their child at the very beginning of school. As one teacher described, "I want to be able to call and say to a parent, 'You know that play sessions project you received a letter about? I think Johnny could really benefit from it.'" She explained this might facilitate a higher rate of involvement by putting parents at ease that their child was not being labeled as having a problem when school had just begun, but instead that teachers wanted to take advantage of resources available to support the children in their adjustment and prevent major problems.

A total of 29 children were referred. The children were required to meet the following criterion in order to be eligible for participation:

(a) child must be enrolled in full day kindergarten at one of the two schools;

(b) child must have the full consent of the legal guardian;

(c) child must participate in at least 12 weekly of 30-minute individual play therapy sessions;

(d) family must expect that the child will remain in the school through March of 2000;

(e) primary care givers must be able to read, write, and speak the English language; and

(f) neither the participants nor their primary care givers will already be in counseling.

Of the 29 identified children, three did not meet the criteria and were dropped from the study. Five additional children were added from parent referrals, after teachers and counselors confirmed that the children were appropriate for the study. After reviewing each child on the basis of the criteria, each child was assigned a code number. The children were then randomly assigned using a random numbers table, with 16 in the treatment group and 14 in the control group. Each child in the treatment group was assigned to an individual play therapy session time slot corresponding to the child's class schedule, after completing three weeks in their kindergarten classroom. Three of the children in the treatment group began play sessions an average of two weeks later than other children due to lack of parental cooperation with paperwork. These children were seen more than once a week to catch up with other children in total number of sessions.

In the treatment group, two of the children were referred for inattentive behavior, 3 for shy behavior, 1 for withdrawn behavior, 2 for anxious behavior, and 5 for multiple reasons- largely attention problems and having experienced significant life changes such as a death in the family or a new sibling. In the control group, 3 children were also referred for a combination of attention problems and significant life changes, 3 for inattentive behavior, 4 for shy behavior, 1 for withdrawn behavior, 2 for anxious behavior, and 1 for depressed behavior. After seeing the children two times, it was determined that two of the children were actually dealing with selective mutism, an extreme case of withdrawn behavior. The researcher believed that having two such extreme cases in the treatment group might skew the results of the study, so again by consulting a random number table, one child was moved into the control group after

having one full play therapy session. This resulted in 15 children in the experimental group and 15 children in the control group.

Between pre and post-testing, one child from the treatment group dropped from the study due to a family move, precipitated by family trauma and two from the control group dropped from the study due to parental withdrawal, with one of these also precipitated by family trauma. The total number of children in each group after these adjustments 14 in the treatment group and 13 in the control group. The McGuire (1999) comparison group had 15 children.

The treatment group consisted of 11 boys and 3 girls, the control group consisted of 6 boys and 7 girls, and the McGuire (1999) comparison group consisted of 5 boys and 10 girls. The participating children were 5 and 6 years old. In an ethnic comparison, the three groups were close to being matched. The experimental group had 10 Caucasians, 3 African Americans, and 1 Hispanic, while the control group had 10 Caucasians, 81 African American, and 2 Hispanics. The McGuire (1999) comparison group had 12 Caucasians, 1 African American, and 2 Hispanics.

Each parent who had a child that met the specified criterion received a full explanation of the purposes and requirements of the study and an opportunity to ask any questions pertaining to the intervention. Informed consent and research information were reviewed in detail with each parent. Participation was voluntary on the part of the parents and it was clearly explained that no child would be forced to participate if he or she became greatly disturbed about going to the playroom. All children went willingly to the playroom with the play therapists.

Collection of Data

A pre-test post-test, control group, comparison group design was used to carry out the objectives of this study. All parameters outlined by McGuire (1999) were closely matched in the collection of data in order to achieve comparable and generalizable results. After parents signed consent forms, they were asked to complete the CBCL, the FPC, and the SCRS prior to the beginning of any treatment with their children. Teachers were also asked to complete the ECBS and the SCRS before any treatment took place.

Prior to receiving any play therapy treatment, each child who participated in the experimental group, comparison group, and the control group was administered the Joseph Pre-School and Primary School Self-Concept Screening Test (JSCS). Directions and questions were read aloud to the children by the trained play therapist administering the test.

The JSCS was re-administered to children in the treatment groups after 12 weeks, when the children had completed 10-12 play therapy sessions. Additionally, parents of children in the treatment and comparison groups were asked to complete the CBCL, the FPC, and the SCRS, considering only the behaviors witnessed within the previous 12 weeks. Teachers were asked to complete the ECBS, and the SCRS with the same instructions. After 12 weeks, the children in the wait-list control group were re-administered the JSCS and parents were asked to complete the post-tests of the CBCL, the FPC, and the SCRS considering only the behaviors that were witnessed within the previous 12 weeks. Teachers were asked to complete the ECBS and the SCRS at this same time.

Treatment

The children who participated in individual play therapy received 10-12 weekly 30-minute sessions of individual child-centered play therapy. Children in McGuire's (1999) study received 12-14 weekly 45 minute child-centered group play therapy sessions. All play sessions took place in the two elementary schools where the children attended school. Each playroom was similarly equipped with play materials as utilized by McGuire (1999) and outlined by Landreth (1991). The children in the control group received no intervention.

The play therapists were three doctoral students in Counselor Education who had been specifically trained in play therapy. Their training included an introductory course in play therapy, an advanced course in play therapy, a course in filial therapy, an advanced doctoral practicum and an internship in play therapy.

Analysis of Data

Scores obtained from the JSCS, CBCL, FPC, SCRS, and the ECBS pre and post-tests from the experimental group were analyzed and compared to the JSCS, CBCL, FPC, SCRS, and the ECBS pre and post-tests from the McGuire (1999) study. In order to determine whether individual child-centered play therapy, child-centered group play therapy or no treatment was the most effective intervention with kindergarten children in the school setting, variations in the JSCS, CBCL, FPC, SCRS, and the ECBS pre-tests and post-test results from individual child-centered play therapy treatment design were

compared with variations in the JSCS, CBCL, FPC, SCRS, and the ECBS pre-tests and post-test from the child-centered group play therapy design and the JSCS, CBCL, FPC, SCRS, and the ECBS pre and post-tests from the wait list control group.

Following the collection of pre-test and post-test data, the instruments were computer scored and hand scored to be double-checked. The data was keyed into a computer and analyzed by the researcher using SPSS for Windows. An Analysis of Covariance (ANCOVA) was computed to test the significance of the differences between experimental group, comparison group and control group. In each case the post-test specified in each of the hypotheses was used as the dependent variable and the pre-test as the covariate. Each set of data was examined to ensure that it met the assumptions for ANCOVA primarily the homogeneity of regression. The data was examined for case outliers that had more impact on the linear regression than the other cases. Any outliers that unduly influenced the statistics were taken out of the equation. ANCOVA was used to adjust the means on the post-test on the basis of the pre-test, thus statistically equating the experimental, comparison and control groups. Significant differences between the means were tested at the .05 level. On the basis of the ANCOVA, the hypotheses were either retained or rejected.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested in this study. Also included is a discussion of the results, implications, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. After testing the data to see if it met the requirement of homogeneity of regression, analyses of covariance were performed on all appropriate data to test hypotheses. A level of significance of .05 was established as a criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

Children in the individual play therapy treatment group will attain a significantly higher mean total score on the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS) post-test than will the children in the control group.

Table 1 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the control group, therefore this subject was removed. One child in the treatment group moved the day before post-testing. These changes resulted in 13 children in the experimental group and 12 in the control group. Table 2 presents the analysis of variance mean gain scores, showing the difference between the experimental and control

groups. Table 3 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 1

Mean scores of the experimental and control group for the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS)

	Experimental Group n = 13		Control Group n = 12	
	Pre-test	Post-test	Pre-test	Post-test
Mean	23.2308	25.0769	23.9167	22.7500
SD	4.2847	3.3031	5.2994	5.2071

Total cases = 25

Note. An increase in the mean score indicates an increase in self-concept.

Table 2

Mean of gain scores of the experimental and control group for the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS)

	Experimental (n = 13)	Control (n = 12)	Total (n = 25)
Gain Mean	1.8462	-1.1667	0.4000
SD	3.9968	5.3058	4.8218

Table 3

Analysis of covariance of the experimental and control groups for the mean scores for the Joseph Pre-school and Primary Self-Concept Screening Test (JSCS)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	42.69864	1	42.69864	2.842	.106	.114	.364
Covariate	98.675130	1	98.675130	6.568	.018	.230	.688
Error	330.498	22	15.023				
Total cases = 25							

* Computed using alpha = .05

Table 3 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental and control groups' post-test scores on the Joseph Preschool and Primary Self-Concept Screening (JSCS). On the basis of this data, hypothesis 1 was not retained.

Hypothesis 2

Children in the individual play therapy treatment group will attain a significantly lower mean total score as rated by the parents on the Self-Control Rating Scale (SCRS) post-test than will children in the control group.

Table 4 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the experimental group, therefore this subject was removed. Two parents of children in the control group did not return the SCRS at post-testing. These changes resulted in 13 children in the experimental group and 11 in the control group. Table 5 presents the

analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 6 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 4

Mean scores of the experimental and control for the Self-Control Rating Scale (SCRS) parent ratings

	Experimental Group n = 13		Control Group n = 11	
	Pre-test	Post-test	Pre-test	Post-test
Mean	123.8462	115.9231	119.6145	127.8182
SD	39.6103	40.9277	31.8305	29.4375
Total cases = 24				

Note. A decrease in the mean score indicates an increase in self-control.

Table 5

Mean of gain scores of the experimental and control group for the Self-Control Rating Scale (SCRS) parent ratings

	Experimental (n = 13)	Control (n = 11)	Total (n=24)
Gain Mean	-7.9231	8.2036	-0.5317
SD	19.7961	21.2258	21.6272

Table 6

Analysis of covariance of the experimental and control groups for the Self-Control Rating Scale (SCRS) parent ratings.

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	1415.188	1	1415.188	3.519	.075	.114	.433
Covariate	20321.260	1	20321.230	50.519	.000	.706	1.000
Error	8445.300	21	402.157				
Total cases = 24							

* Computed using alpha = .05

Table 6 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental and control groups' post-test scores on the Self-Control Rating Scale (SCRS). On the basis of this data, hypothesis 2 was not retained.

Hypothesis 3

Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than will children in the control group.

Table 7 presents pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the experimental group, therefore this subject was removed. One parent of a child in the control group did not return the FPC at post-testing. These changes resulted in 13 children in the experimental group and 12 in the control group. Table 8 presents the

analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 9 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 7

Mean scores of the experimental and control for the Filial Problem Checklist (FPC)

	Experimental Group n = 13		Control Group n = 12	
	Pre-test	Post-test	Pre-test	Post-test
Mean	67.5577	69.6323	51.3333	57.3333
SD	60.9635	55.9217	45.3598	54.4348

Total cases = 25

Note. A decrease in the mean score indicates a decrease of problem behaviors.

Table 8

Mean of gain scores of the experimental and control group for the Filial Problem Checklist (FPC)

	Experimental (n = 13)	Control (n = 12)	Total (n=25)
Gain Mean	2.0746	6.000	3.9588
SD	42.2984	23.4908	33.9337

Table 9

Analysis of covariance of the experimental and control groups for the Filial Problem Checklist (FPC)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	5.511	1	5.511	.005	.945	000	.051
Covariate	44840.991	1	44840.991	39.022	.000	.639	1.000
Error	25280.454	22	1149.112				
Total cases = 25							

* Computed using alpha = .05

Table 9 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental and control groups' post-test scores on the Filial Problem Checklist (FPC). On the basis of this data, hypothesis 3 was not retained.

Hypothesis 4

Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Childhood Behavior Checklist (CBCL)-Parent Report post-test than will the children in the control group.

Table 10 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the experimental group, and one outlier in the control group, therefore these subjects were removed. Three parents of children in the control group did not return the CBC at post-testing. These changes resulted in 13 children in the experimental group and

9 in the control group. Table 11 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 12 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 10

Mean scores of the experimental and control groups for the Child Behavior Checklist-Parent Form (CBCL-Parent Report)

	Experimental Group n = 13		Control Group n = 09	
	Pre-test	Post-test	Pre-test	Post-test
Mean	56.0000	52.7692	52.778	56.3333
SD	9.5131	11.1740	8.7003	13.8924

Total cases = 22

Note. A decrease in the mean score indicates a decrease of problematic behaviors.

Table 11

Mean of gain scores of the experimental and control group for the Child Behavior Checklist-Parent Form (CBCL-Parent Report)

	Experimental (n = 13)	Control (n = 09)	Total (n=22)
Gain Mean	-3.2308	3.5556	-0.4545
SD	6.2069	6.4053	7.0219

Table 12

Analysis of covariance of the experimental and control groups for the mean scores the Child Behavior Checklist-Parent Form (CBCL-Parent Report)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	275.946	1	275.946	7.046	.016	.055	.712
Covariate	2298.162	1	2298.162	58.678	.000	.755	1.000
Error	8445.300	19	402.157				
Total cases = 22							

* Computed using alpha = .05

Table 12 shows the F ratio for the main effects was significant to the <.05 level, indicating there was a significant decrease in the experimental group's total problem behaviors as indicated by the post-test scores on the Child Behavior Checklist (CBCL-Parent Report). On the basis of this data, hypothesis 4 was retained.

Hypothesis 4a

Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Externalizing Behavior Problems Subscale" on the CBCL-Parent Report post-test than will the children in the control group.

Table 13 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed two outliers in the experimental group, therefore these subjects were removed. Three parents of children in the control group did not return the CBCL at post-testing. These changes

resulted in 12 children in the experimental group and 10 in the control group. Table 14 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 15 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 13

Mean scores of the experimental and control groups for the"Externalizing" Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental Group n = 12		Control Group n = 10	
	Pre-test	Post-test	Pre-test	Post-test
Mean	54.6667	50.1667	54.3000	55.6000
SD	11.2519	13.2104	10.3714	14.8937

Total cases = 22

Note. A decrease in the mean score indicates a decrease of problematic behaviors.

Table 14

Mean of gain scores of the experimental and control group for the "Externalizing Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental (n = 12)	Control (n = 10)	Total (n=22)
Gain Mean	-4.5000	1.3000	-1.8636
SD	4.9452	7.7610	6.8820

Table 15

Analysis of covariance of the experimental and control groups for the mean scores the "Externalizing Behavior Problems Subscale" on the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	187.108	1	187.108	4.725	.043	.199	.541
Covariate	3163.616	1	3163.616	79.884	.000	.808	1.000
Error	752.450	19	39.603				
Total cases = 22							

* Computed using alpha = .05

Table 15 shows the F ratio for the main effects was significant to the .043 level, indicating there was a significant decrease in the experimental group's total external problem behaviors as indicated by the post-test scores on the "Externalizing Behavior Problems Subscale" on the CBCL-Parent Report. On the basis of this data, hypothesis 4a was retained.

Hypothesis 4b

Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report post-test than will the children in the control group.

Table 16 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the experimental group, and one in the control group, therefore these subjects

were removed. Three parents of children in the control group did not return the CBCL at post-testing. These changes resulted in 13 children in the experimental group and 9 in the control group. Table 17 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 18 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 16

Mean scores of the experimental and control groups for the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental Group n = 13		Control Group n = 09	
	Pre-test	Post-test	Pre-test	Post-test
Mean	48.3007	48.7692	47.5556	45.0000
SD	13.3441	10.0677	8.4426	11.1018

Total cases = 22

Note. A decrease in the mean score indicates a decrease of problematic behaviors.

Table 17

Mean of gain scores of the experimental and control group for the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental (n = 13)	Control (n = 09)	Total (n=22)
Gain Mean	-0.6923	-2.3000	-1.3913
SD	10.9345	5.6774	8.8920

Table 18

Analysis of covariance of the experimental and control groups for the mean scores the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	57.976	1	57.976	.946	.343	.047	.152
Covariate	1037.579	1	1037.579	16.926	.001	.471	.974
Error	1164.728	19	61.301				
Total cases = 22							

* Computed using alpha = .05

Table 18 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental and control groups' post-test scores on the "Internalizing Behavior Problems Subscale" on the Child Behavior Checklist (CBCL-parent form). On the basis of this data, hypothesis 4b was not retained.

Hypothesis 5

Children in the individual play therapy treatment group will attain a significantly lower mean total scale sum score as rated by the teachers on the "Scale Sum" score of the Early Childhood Behavior Scale (ECBS) post-test than will children in the control group.

Table 19 presents the pre and post-test means and standard deviations for the

experimental and control groups. Homogeneity of regression analysis revealed no outliers, and all teachers returned their ECBS forms at post-testing, so there were 14 children in the experimental group and 13 in the control group. Table 20 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 21 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 19

Mean scores of the experimental and control groups for the Early Childhood Behavior Scale (ECBS) teacher ratings

	Experimental Group n = 14		Control Group n = 13	
	Pre-test	Post-test	Pre-test	Post-test
Mean	19.2143	21.2857	25.000	27.1538
SD	12.6258	11.6119	12.3491	10.9761

Total cases = 27

Note. A decrease in the mean score indicates a decrease of problematic behaviors.

Table 20

Mean of gain scores of the experimental and control group for the Early Childhood Behavior Scale (ECBS) teacher ratings

	Experimental (n = 14)	Control (n = 13)	Total (n=27)
Gain Mean	2.0714	2.1538	2.1111
SD	9.3271	6.4659	8.2235

Table 21

Analysis of covariance of the experimental and control groups for the Early Childhood Behavior Scale (ECBS) teacher ratings

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	20.979	1	20.979	.392	.537	.016	.092
Covariate	1915.647	1	1915.647	35.837	.000	.599	1.000
Error	19127.00	24					
Total cases = 27							

* Computed using alpha = .05

Table 21 shows the F ratio for the main effects not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the control group's post-test scores on the Early Childhood Behavior Scale (ECBS). On the basis of this data, hypothesis 5 was not retained.

Hypothesis 6

Children in the individual play therapy treatment group will attain a significantly lower mean total score as rated by the teachers on the Self-Control Rating Scale (SCRS) post-test than will the children in the control group.

Table 22 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed no outliers, and all teachers returned their SCRS forms at post-testing, so there were 14 children in the experimental group and 13 in the control group. Table 23 presents the

analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 24 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 22

Mean scores of the experimental and control groups for the Self-Control Rating Scale (SCRS) teacher ratings

	Experimental Group n = 14		Control Group n = 13	
	Pre-test	Post-test	Pre-test	Post-test
Mean	144.8667	116.4000	118.6923	101.5385
SD	49.5924	62.0435	56.5750	54.0287

Total cases = 27

Note. A decrease in score represents an increase in self-control.

Table 23

Mean of gain scores of the experimental and control group for the Self-Control Rating Scale (SCRS) teacher ratings

	Experimental (n = 14)	Control (n = 13)	Total (n=27)
Gain Mean	-28.4667	-17.1538	-23.2143
SD	45.0997	24.9795	36.9458

Table 24

Analysis of covariance of the experimental and control groups for the Self-Control Rating Scale (SCRS) teacher ratings

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	391.610	1	391.610	.283	.600	.011	.081
Covariate	54314.265	1	54314.265	39.237	.000	.611	1.000
Error	34606.565	24	1384.263				
Total cases = 27							

* Computed using alpha = .05

Table 24 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental and control groups' post-test scores on the teacher's ratings of the Self-Control Rating Scale (SCRS). On the basis of this data, hypothesis 6 was not retained.

Hypothesis 7

Children in the individual play therapy treatment group will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JSCS) post-test than will the children in the group play therapy comparison group.

Table 25 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed two outliers in the experimental group, therefore these subjects were removed. One child in the experimental group and two children in the comparison group were not post-tested. These changes resulted in 11 children in the experimental group and 13 in the control

group. Table 26 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 27 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' post-test mean scores.

Table 25

Mean scores of the experimental and comparison groups for the Joseph Pre-School and Primary Self-Concept Screening Test (JSCS)

	Experimental Group n = 11		Comparison Group n = 13	
	Pre-test	Post-test	Pre-test	Post-test
Mean	23.8182	26.1818	24.6923	26.4615
SD	4.3317	3.3031	4.5348	2.5038

Total cases = 24

Note. An increase in the mean score indicates an increase in self-concept.

Table 26

Mean of gain scores of the experimental and comparison group for the Joseph Pre-School and Primary Self-Concept Screening Test (JSCS)

	Experimental (n = 11)	Comparison (n = 13)	Total (n=24)
Gain Mean	2.3636	1.7692	2.0417
SD	4.0564	3.6321	3.7588

Table 27

Analysis of covariance of the experimental and comparison groups for the Joseph Pre-School and Primary Self-Concept Screening Test (JSCS)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power*
Main effects	1.352E02	1	1.352E02	.003	.955	.000	.050
Covariate	30.555	1	30.555	7.266	.014	.257	.729
Error	88.312	21	4.205				
Total cases = 24							

* Computed using alpha = .05

Table 27 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the Joseph Preschool and Primary Self-Concept Screening (JSCS). On the basis of this data, hypothesis 7 was not retained.

Hypothesis 8

Children in the individual play therapy treatment group will attain a significantly lower mean total score as rated by the parents on the Self-Control Rating Scale (SCRS) post-test than will children in the group play therapy comparison group.

Table 28 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed one outlier in the experimental group, therefore this subject was removed. Four parents of children in the comparison group did not return the SCRS at post-testing. These changes resulted in 13 children in the experimental group and 11 in the comparison group. Table

29 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 30 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' post-test mean scores.

Table 28

Mean scores of the experimental and comparison group for the Self-Control Rating Scale (SCRS) parent ratings.

	Experimental Group n = 13		Comparison Group n = 11	
	Pre-test	Post-test	Pre-test	Post-test
Mean	123.8462	115.9231	101.1818	95.5455
SD	39.6103	40.9277	34.4320	35.2516
Total cases = 24				

Note. A decrease in the mean score indicates an increase in self-control.

Table 29

Mean of gain scores of the experimental and comparison group for the Self-Control Rating Scale (SCRS) parent ratings.

	Experimental (n = 13)	Comparison (n = 11)	Total (n=24)
Gain Mean	-7.9231	-5.6364	-6.8750
SD	19.7967	12.0023	16.3848

Table 30

Analysis of covariance of the experimental and comparison groups for the mean scores on the total Self-Control Rating Scale (SCRS) parent ratings.

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power*
Main effects	2.647	1	2.647	.009	.924	000	.051
Covariate	26534.774	1	26534.774	92.928	.000	.816	1.000
Error	5992.876	21	285.375				
Total cases = 24							

* Computed using alpha = .05

Table 30 shows the F ratio for the main effects not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the parents' ratings of the SCRS. On the basis of this data, hypothesis 8 was not retained.

Hypothesis 9

Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Filial Problem Checklist (FPC) post-test than will the children in the group play therapy comparison group.

Table 31 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed one outlier in the experimental group, therefore this subject was removed. Four parents of children in the comparison group did not return the FPC at post-testing. These changes

resulted in 13 children in the experimental group and 11 in the comparison group. Table 32 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 33 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison group's post-test mean scores.

Table 31

Mean scores of the experimental and comparison groups on the Filial Problem Checklist (FPC)

	Experimental Group n = 13		Comparison Group n = 11	
	Pre-test	Post-test	Pre-test	Post-test
Mean	67.5577	69.6323	39.9091	46.6364
SD	60.9635	55.9217	47.2450	53.1719
Total cases = 24				

Note. A decrease in the mean score indicates a decrease in problem behaviors.

Table 32

Mean of gain scores of the experimental and comparison group for the Filial Problem Checklist (FPC)

	Experimental (n = 13)	Comparison (n =11)	Total (n=24)
Gain Mean	2.07476	6.7273	1.6943
SD	42.2984	35.2196	37.2447

Table 33

Analysis of covariance of the experimental and control groups for the mean scores on the Filial Problem Checklist (FPC)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power*
Main effects	37.032	1	37.032	.027	.872	.001	.053
Covariate	36500.175	1	36500.175	26.161	.000	.555	.998
Error	29299.149	21	1395.198				

Total cases = 24

* Computed using alpha = .05

Table 33 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the Filial Problem Checklist (FPC). On the basis of this data, hypothesis 9 was not retained.

Hypothesis 10

Children in the individual play therapy treatment group will attain a significantly lower mean total score on the Child Behavior Checklist (CBCL) Parent Report post-test than will the children in the group play therapy comparison group.

Table 34 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed no outliers, and five parents of children in the comparison group did not return the CBC at post-testing. These changes resulted in 14 children in the experimental group and 10 in the comparison group. Table 35 presents the analysis of variance mean gain scores,

showing the difference between experimental and comparison groups. Table 36 presents the analysis of covariance data showing the level of significance of the difference between the experimental and comparison group's post-test mean scores.

Table 34

Mean scores of the experimental and comparison groups for the total Child Behavior Checklist (CBCL-Parent Report)

	Experimental Group n = 14		Comparison Group n = 10	
	Pre-test	Post-test	Pre-test	Post-test
Mean	56.0000	54.3571	47.3000	46.3000
SD	9.5131	12.2701	8.8700	5.6174
Total cases = 24				

Note. A decrease in the mean score indicates a decrease in problem behaviors.

Table 35

Mean of gain scores of the experimental and comparison groups for the total Child Behavior Checklist (CBCL-Parent Report)

	Experimental (n = 14)	Comparison (n = 10)	Total (n=24)
Gain Mean	-1.3571	-1.0000	-1.2083
SD	9.2037	10.6463	7.7627

Table 36

Analysis of covariance of the experimental and comparison groups for the total Child Behavior Checklist (CBCL-Parent Report)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	6.740	1	6.740	.107	.746	.005	.061
Covariate	1347.399	1	1347.399	21.470	.000	.506	.993
Error	1317.915	21	62.758				
Total cases = 24							

* Computed using alpha = .05

Table 36 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the CBCL. On the basis of this data, hypothesis 10 was not retained.

Hypothesis 10a

Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Externalizing Behaviors Problems Subscale" on the CBCL-Parent Report post-test than will the children in the group play therapy comparison group.

Table 37 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed three outliers in the experimental group, therefore these subjects were removed. Five parents of children in the comparison group did not return the CBC at post-testing. These

changes resulted in 11 children in the experimental group and 10 in the comparison group. Table 38 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 39 presents the analysis of covariance data showing the level of significance of the difference between the experimental and comparison groups' post-test mean scores.

Table 37

Mean scores of the Experimental and Comparison group for the "Externalizing Behaviors Problems Subscale" on the CBCL-Parent Report

	Experimental Group n = 11		Comparison Group n = 10	
	Pre-test	Post-test	Pre-test	Post-test
Mean	53.0909	48.0000	49.3000	47.0000
SD	10.3194	11.4018	8.6030	9.4045
Total cases = 21				

Note. A decrease in the mean score indicates a decrease in problematic external behavior.

Table 38

Mean of gain scores of the experimental and comparison group for the "Externalizing Behaviors Problems Subscale" on the CBCL-Parent Report

	Experimental (n = 11)	Comparison (n = 10)	Total (n=21)
Gain Mean	-4.6667	-2.3000	-3.7619
SD	4.7213	6.8807	5.8729

Table 39

Analysis of covariance of the experimental and control groups for the mean scores "Externalizing Behaviors Problems Subscale" on the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power
Main effect	64.438	1	64.438	2.523	.130	.123	.324
Covariate	1546.206	1	1546.206	60.531	.000	.771	1.000
Error	459.794	18	25.544				
Total cases = 21							

* computed using alpha = .05

Table 39 shows the F ratio for the main effects not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the "Externalizing Behaviors Problems Subscale" on the CBCL. On the basis of this data, hypothesis 10a was not retained.

Hypothesis 10b

Children in the individual play therapy treatment group will attain a significantly lower mean score on the "Internalizing Behavior Problems Scale" on the CBCL-Parent Report post-test than will the children in the group play therapy comparison group.

Table 40 presents the pre and post-test means and standard deviations for the experimental and control groups. Homogeneity of regression analysis revealed no outliers, and five parents of children in the comparison group did not return the CBC at post-testing. These changes resulted in 14 children in the experimental group and 10 in

the comparison group. Table 41 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 42 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' post-test mean scores.

Table 40

Mean scores of the experimental and comparison group for the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental Group n = 14		Comparison Group n = 10	
	Pre-test	Post-test	Pre-test	Post-test
Mean	47.9286	50.1429	46.7000	43.000
SD	12.8988	10.9534	10.6463	8.7686

Total cases = 24

Note. A decrease in the mean score indicates a decrease in internalizing behaviors.

Table 41

Mean of gain scores of the experimental and comparison group for the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

	Experimental (n = 14)	Comparison (n = 10)	Total (n=24)
Gain Mean	2.2143	-3.7000	-0.2500
SD	11.8723	6.6508	10.2882

Table 42

Analysis of covariance of the experimental and comparison groups the "Internalizing Behavior Problems Subscale" on the CBCL-Parent Report

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	247.632	1	247.632	3.598	.072	.146	.440
Covariate	806.421	1	806.421	11.717	.003	.358	.904
Error	1445.293	21	68.823				
Total cases = 24							

* Computed using alpha = .05

Table 42 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the "Internalizing Behavior Problems Subscale" on the CBCL. On the basis of this data, hypothesis 10b was not retained.

Hypothesis 11

Children in the individual play therapy treatment group will attain a significantly lower mean total score as rated by the teachers on the "Scale Sum" score of the Early Childhood Behavior Scale (ECBS) post-test than will children in the comparison group.

Table 43 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed one outlier in the experimental group, therefore this subject was removed. All teachers returned the ECBS at post-testing. This change resulted in 13 children in the

experimental group and 15 in the comparison group. Table 44 presents the analysis of variance mean gain scores, showing the difference between experimental and comparison groups. Table 45 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and comparison groups' post-test mean scores.

Table 43

Mean Total Scale Sum scores of the experimental and comparison group for the Early Childhood Behavior Scale (ECBS) Teacher ratings

	Experimental Group n = 13		Comparison Group n = 15	
	Pre-test	Post-test	Pre-test	Post-test
Mean	20.6923	20.8462	26.8000	28.0667
SD	11.8137	11.9642	10.6046	9.1688
Total cases = 28				

Note. A decrease in the mean score indicates a decrease in problematic behaviors.

Table 44

Mean of gain scores of the experimental and control group for the Early Childhood Behavior Scale (ECBS) teacher ratings

	Experimental (n = 13)	Comparison (n = 15)	Total (n = 28)
Gain Mean	0.1538	1.2667	.07500
SD	6.2028	10.6534	8.7332

Table 45

Analysis of covariance of the experimental and comparison groups for the mean scores for Early Childhood Behavior Scale (ECBS) Teacher form

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effect	100.004	1	100.004	4.171	.052	.143	.502
Covariate	22295.255	1	2295.255	95.736	.000	.000	1.000
Error	599.371	25	23.975				

Total cases = 28

* Computed using alpha = .05

Table 45 shows that the F ratio for the main effects was significant at the .052 level, indicating there was a significant difference between the experimental group and the comparison group's post-test scores on the Early Childhood Behavior Scale (ECBS) post-test. On the basis of this data, hypothesis 11 was retained.

Hypothesis 12

Children in the individual play therapy treatment group will attain a significantly lower mean total score as rated by the teachers on Self-Control Ratings Scale (SCRS) post-test than will children in the comparison group.

Table 46 presents the pre and post-test means and standard deviations for the experimental and comparison groups. Homogeneity of regression analysis revealed no outliers, and all teachers returned the SCRS at post-testing. This resulted in 14 children in the experimental group and 15 in the comparison group. Table 47 presents the analysis of variance mean gain scores, showing the difference between experimental and

comparison groups. Table 48 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' post-test mean scores.

Table 46

Mean scores of the experimental and comparison group for the Self-Control Rating Scale (SCRS) teacher ratings

	Experimental Group n = 14		Comparison Group n = 15	
	Pre-test	Post-test	Pre-test	Post-test
Mean	144.8667	116.4000	101.2000	98.7333
SD	49.5924	62.0435	53.5660	44.1159
Total cases = 29				

Note. A decrease in mean score equals an increase in self-control.

Table 47

Mean of gain scores of the experimental and comparison group for the Self-Control Rating Scale (SCRS) teacher ratings

	Experimental (n = 14)	Comparison (n = 15)	Total (n=29)
Gain Mean	-28.4667	-2.4667	-18.0000
SD	45.0997	21.777	38.8222

Table 48

Analysis of covariance of the experimental and control groups for the Self-Control Rating Scale (SCRS) teacher ratings

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F	Eta Squared	Power *
Main effects	1957.464	1	1957.464	1.632	.212	.057	.234
Covariate	48760.130	1	48760.130	40.661	.000	.601	1.000
Error	32378.403	26	1199.200				
Total cases = 29							

* Computed using alpha = .05

Table 48 shows the F ratio for the main effects was not significant to the <.05 level, indicating there was not a significant difference between the experimental group and the comparison group's post-test scores on the teachers' ratings of the SCRS. On the basis of this data, hypothesis 6 was not retained.

Discussion

The results from this study, along with teachers' comments, parents' comments, and the facilitators' observations, provide information regarding the effectiveness of play therapy in the adjustment of at-risk kindergarten children. Of the six hypotheses pertaining to the effectiveness of individual play therapy compared to the control group, 1 of 6 hypotheses was statistically significant, and 1 subscale hypothesis was statistically

significant. Additionally, the results demonstrate a statistically significant difference between individual and group play therapy outcome in 1 of 6 hypotheses. A discussion of the meaning of these results follows.

Comparisons Between Individual Play Therapy and Control Group Self-Concept

Although there was a positive increase in self-concept for the children in the experimental group as measured by the JSCS, the results were not significant at the .05 level. The movement toward a positive trend on the JSCS points to the possibility that individual play therapy with children experiencing adjustment problems facilitates changes in self-concept. Yet because the children had the benefit of the intervention for only twelve weeks, there may not have been enough time for change to be significant. It should be noted that Table 3 reveals a low power of .364 which means that if there was a significant change in self-concept, there would be only a 3.6% chance of finding it. Actual change as measured by this instrument and others in this study may be masked due to the low power caused by the small sample size.

Additionally, these findings have particular meaning given the fact that six children in the control group declined in self-concept, as measured by the JSCS, without any therapeutic intervention, one with an 8-point decrease in score and one with a 7-point decrease. In contrast, seven children in the experimental group experienced an increase in their JSCS scores, with two showing marked 9-point and 8-point increases in their scores. Examination of the mean scores and mean gain scores measured by the JSCS (Table1-2) shows the experimental group averaged a 1.8-point increase in self-concept,

while the control group averaged a 1.2-point decrease in their self-concept scores. The implication of this data is that play therapy helped children in the experimental group to maintain their self-concept while children in the control group experienced a slight decrease in self-concept.

The implications of continued poor self-concept are central to long term social and academic success in school since children with low self-esteem or negative self-concept often view themselves as bad, worthless or unlovable. Children struggling with a negative self-concept often feel unable to impact positively on their environments and they can have difficulty formulating satisfying interpersonal relationships (McGregor & Johnson, 1993). These symptoms may serve to exacerbate difficulties experienced by children experiencing stress from their environments both in and out of school.

Of all the comments play therapists, teachers, and parents made to the researcher, most notable were those regarding the impact of play therapy on the children's self-concept. One boy was observed by the teacher and play therapist as having a dramatic change in his affect, as demonstrated by his increased participation in the classroom and spontaneous interactions with other children at recess. The play therapist described the child as "a totally different child."

Another child whose home environment was reportedly filled with gang violence and chaos was able, for the first time, to accept statements from the teacher about his worth and value. The child had been causing so much disruption in the classroom that the teacher of 17 years almost resigned over her frustration at losing control of her classroom. The teacher communicated that she was deeply moved when the boy began

for the first time to interact with her in a meaningful way. She believed that he had found through his play therapy experience a sense of safety that led to an increase in self-worth when he experienced that the therapist cared enough about him to provide him with limits and freedom to make choices for himself within the safety of the playroom.

Self-Control

Parent Report

Although there was a positive increase in the self-control of the children in individual play therapy as measured by the parents' ratings on the Self-Control Rating Scale (SCRS), the results were not significant at the .05 level. It is important to note that nine of the children in the experimental group demonstrated an increase in self-control, while nine of the children in the control group exhibited a decrease in self-control without intervention. In the experimental group, the scores for three children decreased with one child demonstrating a 34-point decrease, one child a 32-point decrease, and one child a 27-point decrease, indicating an increase in self-control. In contrast, in the control group, one child had a 36-point score increase, one child had a 31-point score increase, and one child had a 25-point score increase, all indicating a decrease in self-control.

An examination of the mean scores and mean gain scores of the SCRS (Table 4-5) revealed that children in the experimental group averaged a 7.9 point increase in self-control while children in the control group averaged a 8.2 point decrease in self-control. This positive trend for the experimental group may indicate that, although the children's behaviors were becoming less problematic, the parents, may have also been viewing their children as still needing to gain a much higher level of self-control compared to other

children their age. The implication of this data is that individual play therapy helped children in the experimental group to increase their level of self-control while children in the control group experienced a decrease in self-control.

Teacher Report

Although there was a positive increase in the self-control of the children in the experimental group as measured by the teachers' ratings on the Self-Control Rating Scale, the results were not significant at the .05 level. An examination of the mean scores and mean gain scores on the SCRS (Table 22-24), showed teachers perceived children in both the experimental group and the control group as having an increase in self-control. The treatment group averaged a 28.5-point increase in self-control, while the control group averaged a 17.1-point increase in self-control. It is important to note that two children in the experimental group had increases in self-control of 111 and 115 points as compared to children in the control group in which the largest gain was 73 points.

Although parents and teachers completed the same instrument, the SCRS, to measure the children's self-control, data from Tables 4-5 and Tables 22-23 shows that the teachers' and parents' perceptions of the children varied greatly. Parents' scores reflect a trend toward gain of self-control for children in the treatment group and a loss of self-control for the children in the control group. Teachers' scores reflect an increase in self-control for children in both the treatment and control groups, with the more positive increase in self-control for children in the treatment group. These differences in the parents' and teachers' scores may be due to the different behaviors that children exhibit in the home and school environments.

Problematic Behaviors of Children

Parent Report

Child behavior checklist. The experimental group showed a significant decrease ($p > .016$) in total behavior problems as indicated by the CBCL-Parent Report (Table 11). These findings are robust and therefore imply a high degree of generalizability to the larger population. The total score includes the scores on all eight factors on the CBCL: a) withdrawn b) somatic complaints, c) anxious/depressed, d) social problems, e) thought problems, f) attention problems, g) delinquent behavior, and h) aggressive behavior. Having a significantly lower mean for total behavior problems at post-testing indicates a reduction of overall behavior problems perceived by the parents.

Additionally, these findings have particular meaning given the fact that six children in the control group showed an increase in problematic behaviors as measured by the CBCL without treatment. One child in the control group attained a marked 19-point increase in his problematic behavior score. In contrast, eight children in the experimental group experienced decreases in their scores, with three children showing marked 15, 12, and 11-point decreases in their scores.

Additionally, the experimental group showed a significant decrease ($p > .043$) in external behavior problems as indicated by the Externalizing Behavior Subscale of the CBCL-Parent Report (Table 15). These findings are robust and therefore imply a high degree of generalizability to the larger population. Children in the control group had an average increase of 1.3 points in their external behavior problems, while children in the experimental group had an average decrease of 4.5 points in their problematic

externalizing behaviors (Table 14). The implication of this data is that parents viewed the children who received individual play therapy as decreasing in outward manifestations of inner conflict in areas including aggression, hyperactivity, and conduct problems.

Scores on the Internalizing Behavior Problems Subscale (Table 16-18) show that children in the experimental group had no change in internalizing behaviors such as withdrawal, anxiety, depression, and suicidal ideation, while children in the control group had an increase in these problematic internalizing behaviors on the CBCL. These results suggest that parents viewed children who received no treatment as experiencing increasingly problematic behavioral characteristics symptomatic of an attempt to cope with internal difficulties.

It is interesting to note that parent's scores on the FPC and the CBCL do not reflect similar behavioral levels for the children, although both instruments are designed to measure problem behaviors. This could be due to the fact that the FPC was designed to measure the change in parental perception of children's problematic behaviors when the parents are directly involved in the therapeutic process of filial therapy. Perhaps in this study, where the level of parental direct involvement was extremely low, this instrument was not as sensitive to the type of change that did occur in children's behaviors. It should also be noted that the FPC asks a number of questions directly related to school behavior, such as items: 4) Gets lower grades in school than should, 26) Cannot keep mind on studies, and 34) Never chosen as leader". It is possible that parents did not know what type of behaviors their children were exhibiting at post-testing since the teachers reported low involvement of the parents at the school and the study took

place the first semester. Parents may have scored the school related items as if they were not a problem, thus reducing the chance of finding a significant change in the children's overall behaviors at post-testing.

Comparisons Between Individual and Group Play Therapy

Table 49 presents the analysis of variance mean gain scores for the experimental, comparison, and control groups. These scores and the associated N (number of subjects) for the experimental and comparison groups were taken directly from previous Tables 25-48. The scores and the N for the control group came directly from Tables 1-24. The data is shown only to give an estimate of data trends, since the three groups were only compared in groups of two for ANCOVA, and not directly compared in an MANCOVA.

Table 49

Mean of gain scores of the experimental, comparison , and control groups

	Experimental	Comparison	Control
JSCS	(n =11) 2.3636	(n = 13) 1.7692	(n = 12) –1.667
SCRS- parent	(n = 13) –7.9231	(n = 11) –5.6364	(n = 11) 8.2036
FPC	(n = 13) 2.0746	(n = 11) 6.7273	(n = 12) 6.000
CBCL-total	(n = 14) –1.3571	(n = 10) –1.000	(n = 09) 3.5556
CBCL-external	(n = 11) –4.6667	(n = 10) -2.3000	(n = 12) 1.3000
CBCL-internal	(n = 14) 2.2143	(n = 10) –3.7000	(n = 09) –2.3000
ECBS	(n = 13) 0.1538	(n = 15) 1.2667	(n = 13) 2.1538
SCRS- teacher	(n = 14) –28.4667	(n = 15) –2.4776	(n = 13) –17.1538

Scores on three of the six instruments utilized in this study show that positive change occurred in children who received individual or group play therapy, while children with no treatment showed negative change. These instruments included the Joseph Preschool and Primary Self-Concept Screening Test (JSCS), the Self-Control Rating Scale (SCRS) (on parent ratings), the Child Behavior Checklist (CBC) (on both the total score and externalizing behaviors subscale). Additionally, the Early Childhood Behavior Scale (ECBS) data showed that individual play therapy was significantly more effective than group play therapy in helping children maintain their behavior level. Children in the control group had a larger increase in problematic behaviors than the children who received individual or group play therapy.

Although the treatment, comparison, and control groups in this study were not directly compared, the data in Table 49 shows a positive increase in the measured self-concept of children with adjustment problems in individual and group play therapy, while the self-concept of the children in the control group decreased. This finding is consistent with the Pelham (1972) study which found that measured self-concept of socially immature children involved in individual and group play therapy increased significantly as compared to the control group. This study is also consistent with the findings of Perez (1987), who found that sexually abused children in individual or group play therapy gained self-control over traumatic events and increased their positive self-concept when compared to a control group.

The results of this study are inconsistent with the results of the Tyndall-Lind (1999) study. She compared the effects of sibling group and individual play therapy with child witnesses of domestic violence and found that children in intensive group play therapy showed more positive change on the CBCL Internalizing and Externalizing subscales than children in the intensive individual play therapy. It is likely that the dynamics of intensive sibling group therapy and group play therapy with two children are vastly different and not directly comparable. The differences in the results of these two studies are interesting and warrant further investigation into various forms of group play therapy and with groups of children dealing with many different issues.

The Therapeutic Process

Children who were recommended for this study by teachers and parents fell into many subcategories of adjustment difficulties, including withdrawn, anxious, inattentive, depressed and shy behaviors, and children who had experienced significant life changes such as divorce, a new sibling, or moving. At least 11 of the 28 children were exhibiting extreme behaviors due to some very complex issues in their lives. Random selection resulted in the majority of these children being placed in the treatment group. This lack of balance between the experimental and control groups on the severity of child behaviors certainly may have impacted the results.

Recommendations

1. Conduct a replication of this study using a larger sample size to increase the power of statistical measures and reduce error level.

2. Conduct a replication of this study using one sample pool for all levels of treatment to compare the effects of individual play therapy, group play therapy, and no treatment.
3. Conduct a replication of this study implementing new instruments that would be more sensitive to subtle changes in the children's behaviors.
4. A follow-up study should be conducted to evaluate longer play sessions to compare the impact of length of sessions on children's play themes and external behavior.
5. A follow-up study should be conducted to evaluate the long-term effects of individual and group play therapy with kindergarten children experiencing adjustment difficulties.
6. Further research is needed to compare the effectiveness of individual versus group play therapy for specific issues including, but not limited to inattentive behaviors, shy behaviors, withdrawn behaviors, selective mutism, social difficulties, aggressive behaviors, etc.
7. Further research is needed to investigate intensive individual and group play therapy in the elementary schools with kindergarten children at risk for adjustment difficulties. A larger sample size may yield more powerful results.

Concluding Remarks

This study has demonstrated limited and yet promising results for play therapy with kindergarten children experiencing adjustment difficulties. Most important is the

prospect of positive results of play therapy as an early intervention for children at risk for problem behaviors, problems with self-control, and negative self-concept. The results specific to a decrease in external behavior problems have a great deal of promise in terms of creating new patterns of interacting with peers, teachers, and family members. Another important finding was that individual play therapy helped to prevent an increase in problem behaviors as perceived by teachers.

APPENDIX A

CHILD SELECTION FORM

Hodge Elementary School
Supportive Play Sessions for Kindergarten Children

Dear Teachers,

Welcome to the new school year! I am excited about getting to know you and your students and beginning this year's play therapy project. This year individual play sessions will be available to help support the kindergarten children in their adjustment to school. We plan to have at least twelve sessions for the children from now through the end of the semester. The sessions will be thirty minutes long and will be provided by myself or other trained University of North Texas doctoral students.

Benefits to kindergarten children include:

- Increased Self-Esteem
- Increased Self-Direction
- Increased Self-Confidence
- Increased Self-Control
- Increased Social Skills
- Decreased Dependency
- Decreased Behavioral Difficulties

Please nominate at least two children or a maximum of three kindergarten children from your classroom. All children may not participate in the play sessions, but please nominate at least two to allow for some extra possibilities. Children who would benefit most from the play sessions could demonstrate behaviors such as:

- Shy Behavior
- Withdrawn
- Anxious behavior (fearful, self-conscious, nervous)
- Somatic complaints (stomach ache, dizzy)
- Depressed Behavior (cries excessively, sad, loner)
- Inattentive Behavior (doesn't concentrate, day-dreams)
- Aggressive Behavior (temper, screams, fights)
- Social Problems (teased, doesn't get along with others)

OR The child has experienced a life change within the last year such as:

- Parent's divorce
- Death in the family
- Family Move
- New Sibling

Please rank your identified students according to who you recommend be given first priority for the play sessions and turn in your list to your school counselor, Vangee Deussen on or before Friday, August 27. We hope to begin the play sessions the following week.

Thank you so much for your enthusiasm and help! If you have questions about nominations, ranking children, or about the play sessions or even concerns about a specific child, please feel free to contact Vangee Deussen or myself (Robyn Rennie) at (940)565-3864.

Thank you!
Robyn Rennie, University of North Texas

APPENDIX B

PLAY THERAPY INFORMATION LETTER TO PARENTS

AND

INFORMED CONSENT

PARENT INFORMATION

You and your child are invited to participate in a Special program at your child's elementary School set up to provide kindergarten children with additional support to the adjustments they will have to their new school environment. This program consists of 16 once-a-week, 30 minute individual, special structured play times with a play therapist trained at the University of North Texas. This program is designed to help your child gain self-esteem, self-control, and self-confidence

This program is part of a study to determine the effectiveness of special structured individual play sessions with kindergartners in comparison to group play sessions held last year. The program is under the direction of Dr. Garry Landreth, Regent Professor in the Department of Counselor Education at the University of North Texas. Robyn Rennie is the coordinator of this program, and she is a trained play therapist and a Doctoral Candidate at the University of North Texas.

Your participation and your child's participation are completely voluntary. If you choose to participate, you will be asked to complete four questionnaires before the play sessions begin, again after ten weeks, and after the last play session. Your child will be asked to participate in a thirty minute play session once a week for twenty weeks during the school day, and to complete two screening instruments administered by a trained professional. Your child's teacher will also be asked to complete questionnaires before at the same three intervals.

The information you provide when you and your child answer the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires will be recorded with a code number. Only the coordinators, the school counselor, and the teachers of the children in the program will have a list of the participants' names. The research assistants will have no knowledge of participants' names and they will abide by the same confidentiality standard. The only exceptions to confidentiality are if and when a) the child discloses abuse, neglect, or exploitation, b) the child is a danger to /herself or to someone else, c) a court orders disclosure of information, or d) the parent or legal guardian requests release of information.

There is no personal risk or discomfort directly involved with this study. You and/or your child may choose to withdraw for the study at any time without penalty or prejudice. Your decision whether or not to participate will in no way affect your child's standing in his or her classroom or school. At the conclusion of the study, a summary of group results will be made available to all interested parents and teachers.

If you agree to participate, please fill out and sign the attached consent form. For further information, please contact, Vangee Deussen, School Counselor at (940) 383-4634, or Robyn Rennie, Researcher, at (940) 565-2066, or Dr. Garry Landreth, Faculty Supervisor, at (940) 565-2916.

Thank you for your cooperation. I look forward to getting to know you and your child.

Robyn Rennie

PARENT INFORMED CONSENT
FOR HODGE ELEMENTARY SCHOOL
KINDERGARTEN ADJUSTMENT PROGRAM

You are making a decision whether or not to participate to this program. You should not sign until you understand all the information presented in the attached letter and until all your questions about the program have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may chose to withdraw at any time during the program. Your signature indicates that (1) you have read the information in the attached letter, (2) you and your child have decided to participate, and (3) you will meet all the requirements for participation as indicated below.

REQUIREMENTS FOR PARTICIPATION

1. **Parent(s) and their kindergarten child are willing for the kindergarten child to participate in 16 once-a-week thirty minute play sessions with a qualified play therapist.**
2. **The family must be planning to remain in Hodge Elementary School through May of 2000, the end of the school year.**
3. **The kindergarten child and parent(s) are not currently receiving counseling.**
4. **Parent(s) must be able to read, write, and speak the English language and the kindergarten child must be able to speak the English language.**

Signature of Parent or Legal Guardian	Date
Printed Name of Parent or Legal Guardian	Date
Signature or Mark of Kindergarten Child	Date
Printed Name of Kindergarten Child	Date
Signature of Researcher	Date

This program has been reviewed and approved by the University of North Texas Institutional Review Board for the protection of human subjects. (940) 565-3940.

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week period in their elementary school. The comparison group, utilized from the 1999 McGuire study, consisted of 15 children with adjustment problems and received 12-14, 45-minute group play therapy sessions in 14 weeks in their elementary school. The control group, consisting of 13 children experiencing adjustment problems, received no play therapy intervention over a 12 week period.

An Analysis of Covariance revealed significant findings in 1 of the 6 hypotheses and one subscale hypothesis examining the effectiveness of individual play therapy versus the wait list control group. Specifically, children with adjustment problems in the experimental group exhibited a significant reduction in total behavior problems and a significant reduction in externalizing behavior problems as measured by the Child Behavior Checklist-Parent Form (CBCL). Additionally, an Analysis of Covariance revealed significant findings in 1 of the 6 hypotheses examining the comparison of the effectiveness of individual play therapy versus the group play therapy comparison group from McGuire (1999). Individual play therapy was significantly more effective than group play therapy in helping children maintain an acceptable level of classroom behaviors as perceived by teachers on the Early Childhood Behavior Scale (ECBS).